DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 11011 (Rev. 01/03)

STATE OF WISCONSIN

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / BIRTH TO 3 THERAPY ATTACHMENT (PA/B3)

Wisconsin Medicaid requires information to enable Medicaid to authorize and pay for medical services provided to eligible recipients.

Recipients are required to give providers full, correct, and truthful information for the submission of correct and complete claims for Medicaid reimbursement. This information should include, but is not limited to, information concerning eligibility status, accurate name, address, and Medicaid identification number (HFS 104.02[4], Wis. Admin. Code).

Under s. 49.45(4), Wis. Stats., personally identifiable information about Medicaid applicants and recipients is confidential and is used for purposes directly related to Medicaid administration such as determining eligibility of the applicant, processing prior authorization (PA) requests, or processing provider claims for reimbursement. Failure to supply the information requested by the form may result in denial of PA or Medicaid payment for the services.

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form and is formatted exactly like this form. If necessary, attach additional pages if more space is needed.

REMINDER TO PROVIDERS
Providers are reminded that all services must meet the rules and regulations of Wisconsin Medicaid as found in HFS 101-108, Wis. Admin. Code. Providers are further reminded that PA does not guarantee payment for the service.

SUBMITTING PRIOR AUTHORIZATION REQUESTS
Attach the completed Prior Authorization/Birth to 3 Therapy Attachment (PA/B3) to the Prior Authorization Request Form (PA/RF) and send it to Wisconsin Medicaid. Providers may submit PA requests by fax to Wisconsin Medicaid at (608) 221-8616. Providers who wish to submit PA requests by mail may do so by submitting them to the following address:

Wisconsin Medicaid
Prior Authorization
Ste 88
6406 Bridge Rd
Madison WI 53784-0088

Name — Recipient (Last, First, Middle Initial)	Recipient Medicaid Identification Number
Name — Therapist (Last, First, Middle Initial)	Therapist's or Rehabilitation Agency's Medicaid Provider Number

By my signature below, I hereby attest that:

- I am providing an evaluation completed for the purpose of determining the recipient's eligibility for the Birth to 3 (B-3) Program or for the purpose of initiating and/or providing therapy services as part of the Individualized Family Service Plan (IFSP) developed for the recipient.

OR

- I am providing ongoing therapy services and I certify that all of the following are true:
  - √ The IFSP for the child named above was or will be developed and implemented in accordance with the requirements set forth in HFS 90, Wis. Admin. Code.
  - √ The therapy services I am providing to the recipient named above are as stated in the child's current and valid IFSP.
  - √ The frequency and duration of services I am providing to the child named above reflects the frequency and duration of services listed in the recipient's IFSP.
  - √ The recipient of the services is enrolled in a B-3 Program for all dates of service and is younger than three years of age.
  - √ I am a therapist employed by a B-3 Program or am under agreement with a B-3 agency to provide B-3 services.
  - √ The therapy services provided meet all the applicable rules and regulations as stated in HFS 101-108, Wis. Admin. Code, and *Wisconsin Medicaid and BadgerCare Updates*.
  - √ I understand that I am required to maintain a record of services provided to the child named above, per HFS 106, Wis. Admin. Code.

SIGNATURE — Therapist	Date Signed (MM/DD/YYYY)

Reset Form